Governor's Commission on Medicaid Managed Care

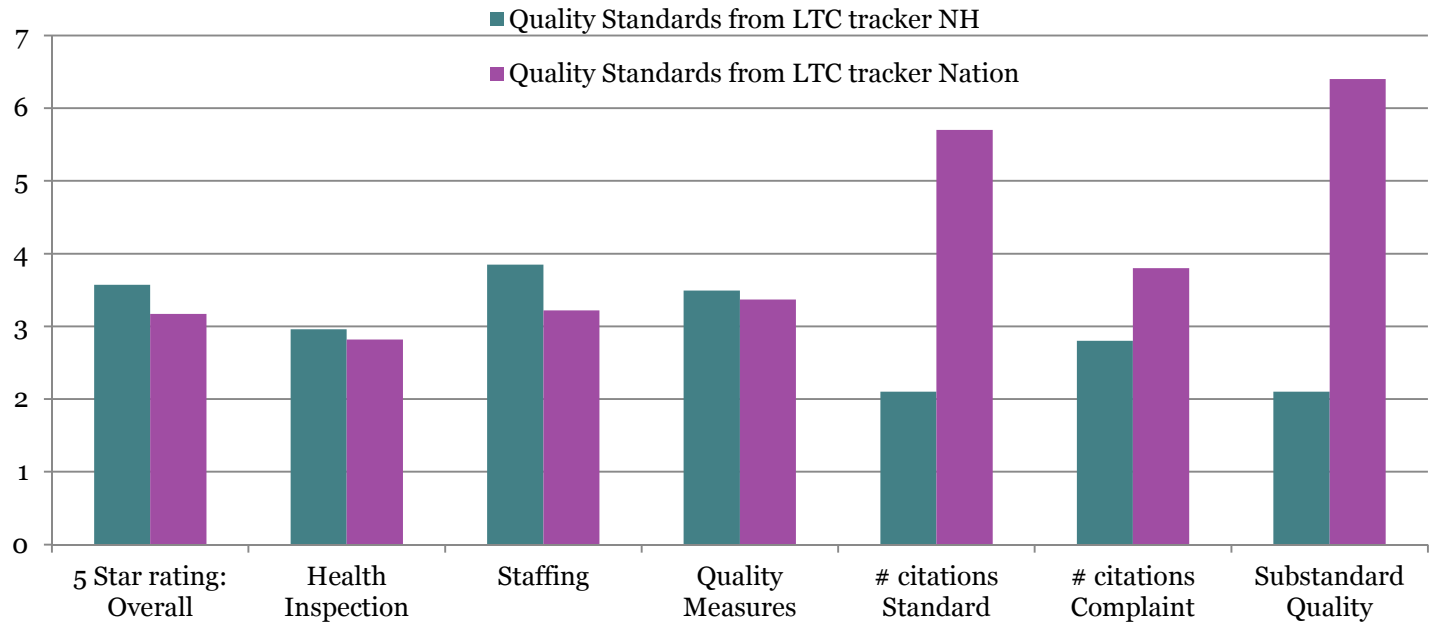
Long Term Care – Step 2:

Understanding today, as we move to tomorrow.

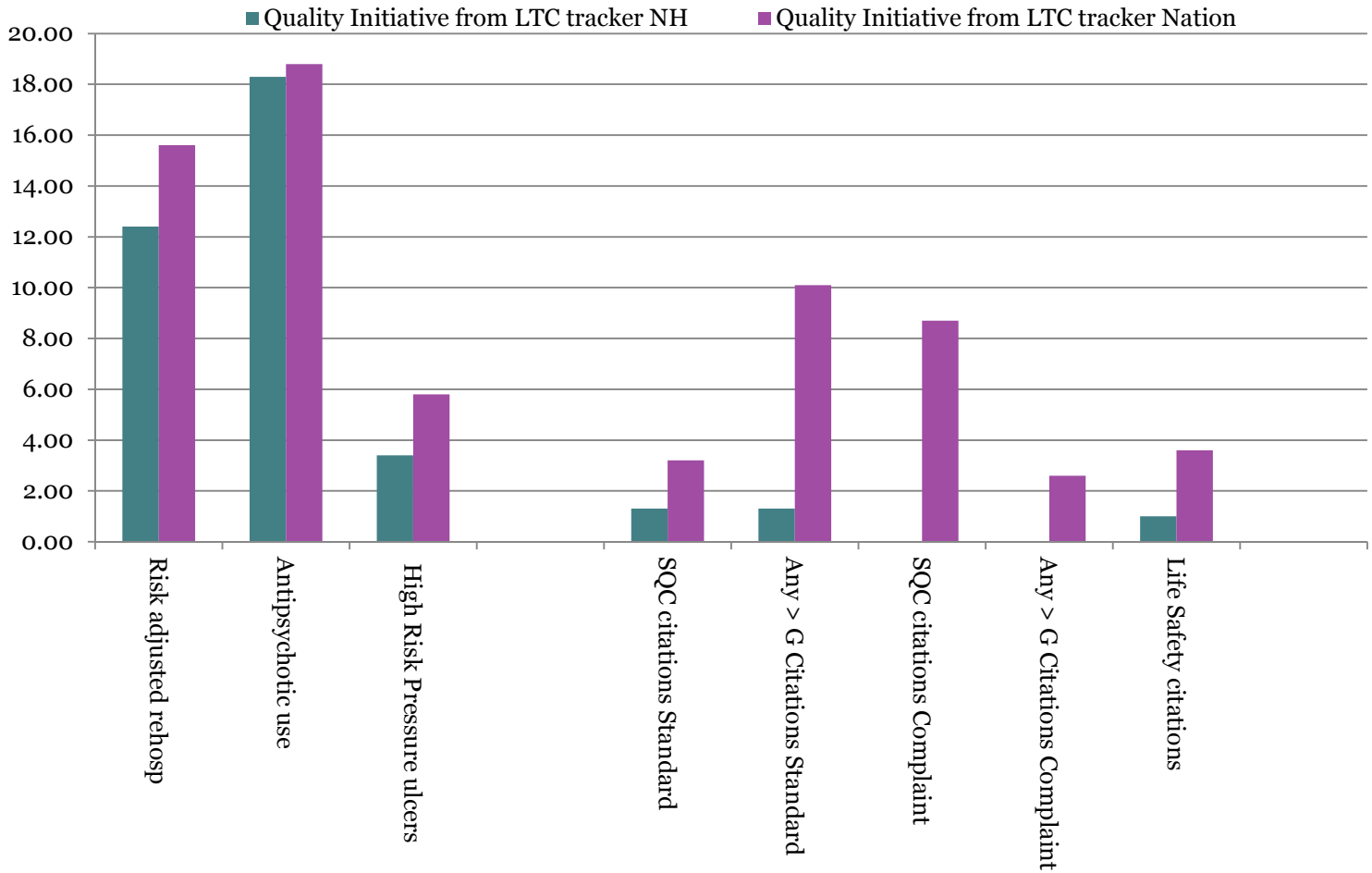
Presented by NH Health Care Association and NH Association of Counties
6/11/15

- Quality of LTC services today – the Heart of what we do!
- How LTC is Funded
- How SNF's are Reimbursement
- Important principles for LTCSS in Step 2
- Timeline to do it right
- Where is Step 2 taking us? Our questions

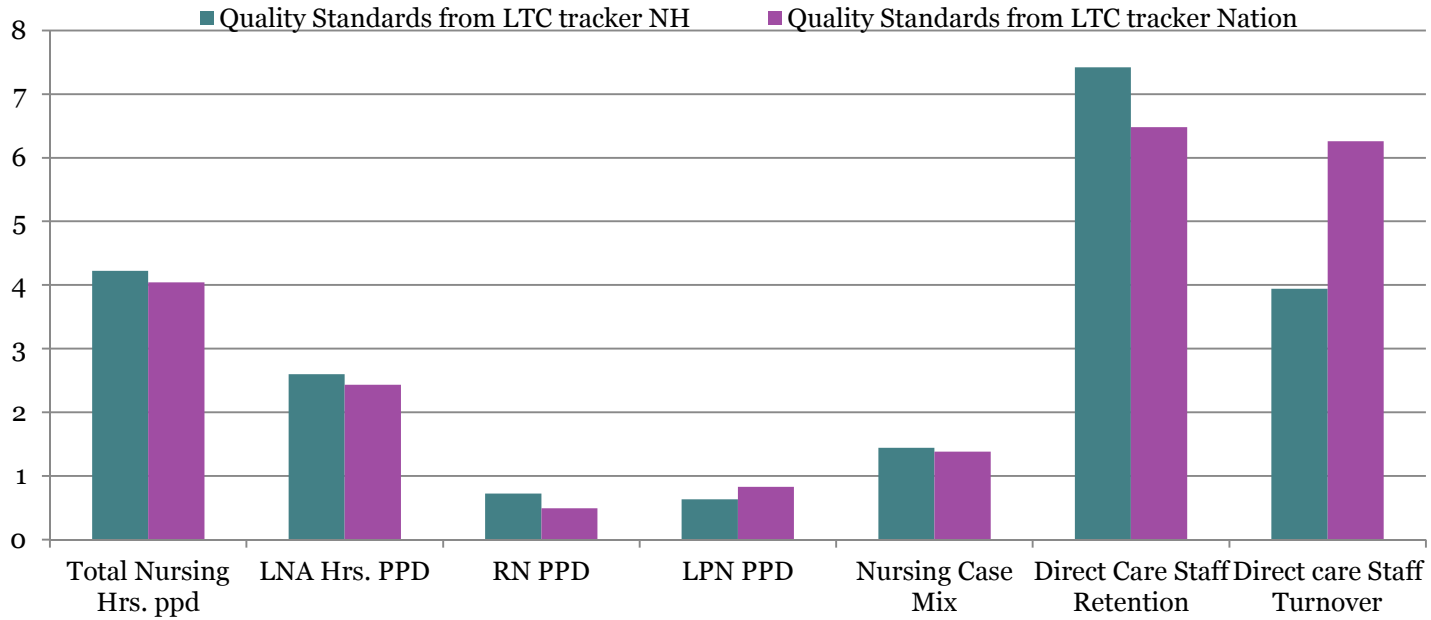
Quality today in LTC in NH – We can all be proud!



Quality today in LTC in NH – We can all be proud!



Quality today in LTC in NH – Staff we can all be proud!



A Nursing Home's funding is a 3-legged stool

- Private Pay and other = 20.8%

  rates are amongst the highest in US. – impoverished quickly.

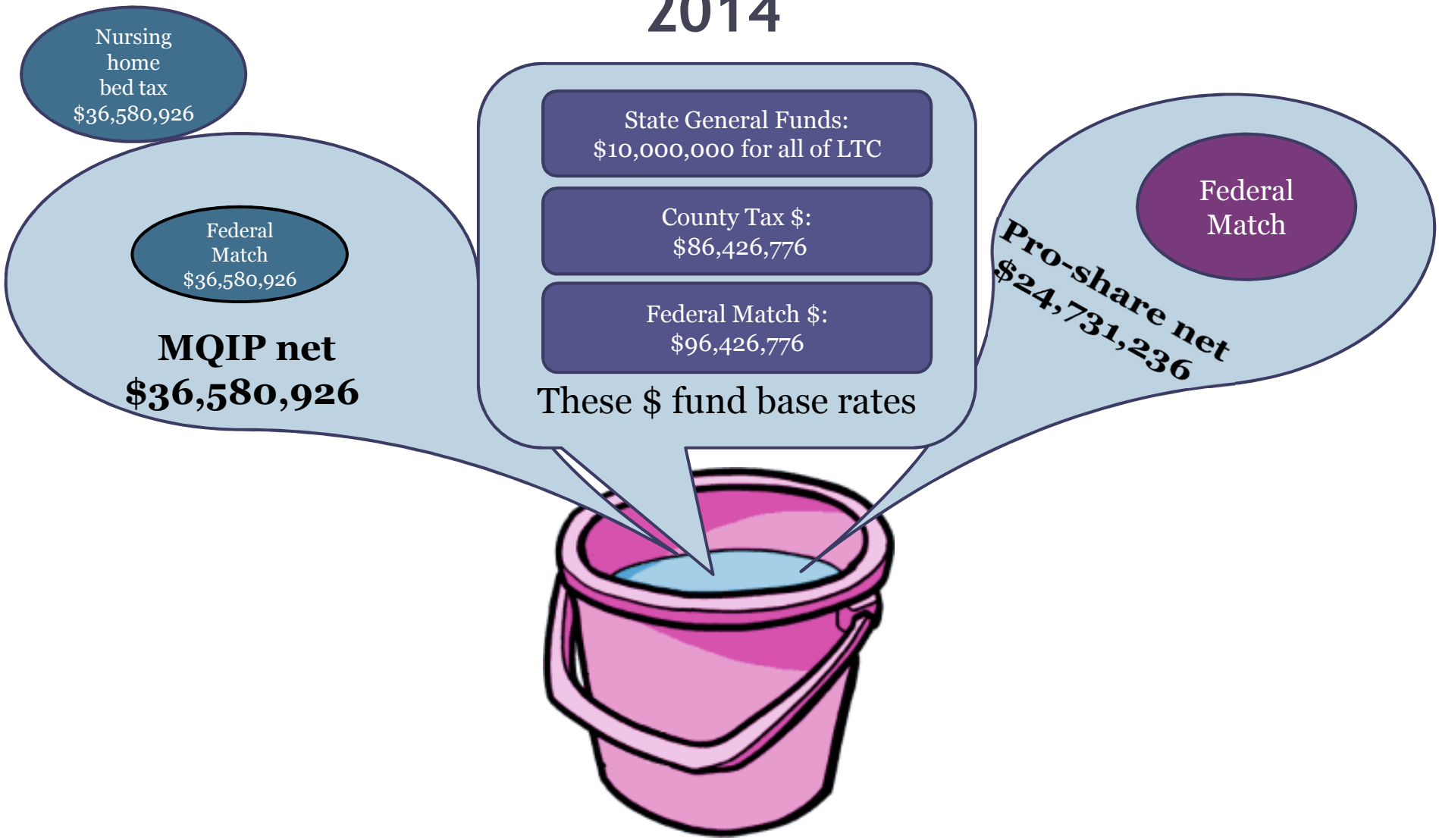
- Medicare = 14.1%

- Medicaid = 65.1%

nursing homes as provider group are highly dependent on Medicaid $.

Cost shifting, because Medicaid funding is so low, to Private and higher revenue producers like Medicare and Insurance patients, and county tax payers for the County Nursing Homes

Where does Medicaid funding come from? Who fills the bucket? 2014



How is it distributed? Rate "calculations"

- **Cost reports**: reduces costs to "allowable costs"
- **Caps applied**: "allowable costs" capped to median of base year collective costs
- **Acuity** – 2x/ year & reweighted
- **Budget neutrality applied:** reduces calculated cost based payment rate to assure payments don't exceed state budget.

Budget Neutrality Factor first appeared on rate sheets 10/2001 and was **2.75%**.
2002 @ **5.96%**, 2/2003 @ **6.39%**, 8/2003 @ **14.69%** 1/2014 **25.12%**

July 1,2015 @**29.82%**

This system is not for the faint hearted

New Hampshire Medicaid Payment Calculations
Rate Effective: July 1, 2015

Provider Number:
Report Period Ending: 12/31/2011

1. Calculation of Cost Per Day Amount	Costs			Resident Days			
	ICF and SNF Total	Special Needs Adjustment	Adjusted Costs	ICF and SNF Total	Special Needs Days	Adjusted Days	Adjusted Cost Per Day
	A	B	C=A*(1-B)	D	E	F=D-E	G=C/F
Patient Care Costs	$ 2,313,842						
Therapy (Physical, Occupational, Speech)	$ 0	N/A*	0	10,902	N/A*	10,902	$ 0.00
Patient Care, Net of Therapy	$ 2,313,842	0.00%	2,313,842	22,883	0	22,883	$101.12
Administrative Costs	$ 966,935	0.00%	966,935	22,883	0	22,883	$ 42.26
Other Support Costs	$ 1,148,061						
Plant Maintenance Costs	$ 366,593	0.00%	366,593	22,883	0	22,883	$ 16.02
Other Support Net of Plant Maintenance	$ 781,468	0.00%	781,468	22,883	0	22,883	$ 34.15
Depreciation and Interest Costs	$ 458,552	0.00%	458,552	22,883**	0	22,883	$ 20.04

*Notes: *See below (4. Therapy Rate Calculation)*
***Days are the higher of adjusted days or the imputed days at 85% occupancy*

2. Inflation: Mid-Point Cost Report to Target Inflation Date

8.219%

3. Case-Mix Indices

All Payer	1.00615
Medicaid	0.9635

Draft and Preliminary
5/29/2015

New Hampshire Medicaid Payment Calculations
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4. Therapy Rate Calculation

Cost Report Data - Inflated			Compare Facility-Specific to Ceiling		Therapy Cost Excluding Special Needs					
Theapy Cost Per Day, Per Cost Report	Inflation To Target Inflation Date	Inflated Therapy Cost Per Day	2012 Allowable Therapy Costs Ceiling	Rate Equals Lower Of Facility-Specific Cost Or Ceiling	Total LTC Patient Days	Total Allowable 2012 Therapy Cost	Special Needs Factor	Allowable 2012 Therapy Cost, Excluding Special Needs	Total LTC Patient Days, Excluding Special Needs	Allowable 2012 Therapy Per Diem, Excluding Special Needs
A	B	C=A*(1+B)	D	E=Lower of C or D	F	G=E*F	H	I=G*(1-H)	J	K=I/J
0.00	8.219%	0.00	4.32	0.00	10,902	0	0.00%	0	10,902	0.00

5. Direct Care Rate Calculation

Cost Report Data - Inflated			All-Payer Case-Mix Adjustment		Determine Ceiling, Based on Median	Compare Facility-Specific	Medicaid Case-Mix Adjustment	
Direct Care Cost Per Day, Per Cost Report	Inflation To Target Inflation Date	Inflated Cost Per Day	Divide By All-Payer Case-Mix Index	Case-Mix Adjusted Cost Per Day	Ceiling (Median Case-Mix Adjusted Cost Per Day, From 2012 Cost Reports, Inflated To Target Inflation Date	Patient Care Base Rate Equals Lower Of Facility-Specific Cost Or Ceiling	Multiply By Medicaid Case-Mix Index	Case-Mix Adjusted Patient Care Rate Per Day
A	B	C=A*(1+B)	D	E=C/D	F	G=Lower of E or F	H	I=G*H
101.12	8.219%	109.4			Median			
		Allowable Therapy Per Diem						
		0.00						
Sum of Direct Care and Therapy		109.4	1.0062	108.76	120.74	108.76	0.9635	104.79

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6. Other Rate Components Calculation

	Cost Report Data - Inflated			Rate Basis
	Cost Per Day A	Inflation To Target Inflation Date B	Inflated Cost Per Day C=A*(1+B)	Median Cost Per Day, From 2012 Cost Reports, Inflated Target Inflation Date D
Administration Rate	42.26	8.219%	45.73	39.61
Other Support Rate	34.15	8.219%	36.96	44.43
Plant Maintenance Rate	16.02	8.219%	17.34	15.73

	Cost Per Day (Capital Component Not Inflated)	85th Percentile Ceiling	Lower Of Actual Or Ceiling
Capital Rate	20.04	15.94	15.94

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7. Summary Of Rate Components

Direct Care	$ 104.79
Administration	39.61
Other Support	44.43
Plant Maintenance	15.73
Capital	15.94
Total	$ 220.50

7. Budget Neutral Factor - 29.82% -65.75

8. Medicaid Payment Rate **154.75**

Draft and Preliminary
5/29/2015

Principles to Govern LTC Managed Care

1. **Quality of care is paramount.** The transition to MMC should not directly or inadvertently impair the quality of care or quality of life experienced by long term care recipients and nursing home residents.

2. **NH DHHS should continue to be the rate setter for facility based care,** but if it is to become a negotiated rate with the MCOs, then it needs to transition over at least 4 years for stability of providers. (precedent of Medicare changes and NH transition to acuity based Medicaid.)

3. Any "rebalancing" of the care delivery system, should not be funded at the further expense of nursing homes. **AND** other providers need to be funded to support quality care and choices, as well. (Assisted Living, Home Health, Home and Community Based Care.)

4. Enrollment in a MMC should not proceed until principals are agreed to and differences for choice are understood.

5. Any willing provider should be allowed to contract for MMC services. Access to services is already an issue in rural areas. There should be no added qualifications other than Medicaid and Medicare licensure.

6. All current Medicaid nursing home residents should be assured that they will not be discharged to another level of care unless they voluntarily, personally make such a request.

7. The administrative processes of all MMC plans should be consistent for all major functions such as prior authorizations, claims processing and appeals for eligibility related matter. There should be no ADDED administrative burden on providers.

8. Previously approved **capital cost** that have been **included in reimbursement rates** should continue to be recognized and compensated in any revised reimbursement formula, and the system should recognize the need for further capital improvement to aging facilities **and** continue to provide an **atypical rate for special populations**.

9. The reimbursement formulas applied to any class of LTC services should be neutral to type or form of ownership. No form of ownership should be advantaged or disadvantaged by state policy. We understand that all payments need to be rolled into one rate under managed care. However, pro-share and MQIP need to be included.

10. Grievance and appeals process for both individual long term care recipients and long term care providers should be established that include accessible, knowledgeable, high level liaisons. In the case of recipients the liaison should function as a “managed care ombudsman”.

11. NH DHHS should continue to be responsible for determining clinical eligibility for nursing home care to assure uniform application of standards.

12. Pro-Share and MQIP funding are significant aspects of the reimbursement system and need to continue to flow to providers in an auditable / transparent methodology.

Suggested Timeframe to successfully implement Step 2

• Develop concurrence among DHHS, MCOs and provider community of principles, including payment system, that will guide contract framework between DHHS and MCOs and between MCOs and providers.	6 months
• Negotiate & Develop State to MCO contract terms Re LTCSS	3 months
• File CMS 1115 waiver (based on outcome of contracts) ???	1 month
• Negotiate & Develop MCO to LTC provider contract terms, reimbursement system, quality measures, payment methodology,	5 months
• Educate providers, recipients and families on managed care contracts	2 months
• Initiate and conduct mandatory enrollment of LTC recipients (after contract terms are completed and explained)	2 months
• Initiate managed care contracts in alignment with state budget cycle	July 2017?

Moving forward…..

- LTC provider community, private and county, is willing to partner with DHHS and MCOs to successfully implement Step 2;
- We look forward to our next meeting with the Commissioner;
- We want to do it RIGHT!

Global questions:

1. What are the goals and objectives of implementing managed care for the nursing home and mid-level residential populations? In particular:

   a. What specific quantifiable financial savings opportunities, identified by NH DHHS, are expected to be achieved by implementing managed care for nursing home residents?

   b. What specific or quantifiable quality improvement or care coordination opportunities, identified by NH DHHS, are expected to be achieved by implementing managed care for nursing home residents?

   c. In light of the very low Medicaid reimbursement rates for Residential Care services and the resulting very low acceptance of Residential Care residents by the provider community, does NH DHHS see an opportunity to adjust mid-level care rates so that additional facilities will accept Medicaid recipients and provide a viable placement option for lower acuity individuals who need 24 hr. access to supportive care?

   d. What specific quantifiable financial savings or improvements in quality of care coordination are expected to be achieved by implementing managed care for Mid-level "Residential Care or Supported Residential Care" residents?

Global questions continued:

2. What systems will be put in place to monitor the care received by residents of nursing homes, given this population's limited ability to self-report disruptions in service that may be triggered by systematic changes? What if any consideration has been given to the totality of this population's dependence on the care provided by nursing homes and affiliated ancillary service providers?

   a. What are the potential care coordination and care delivery problems that DHHS has identified as being the most likely to arise as a result of any anticipated changes resulting from implementation of managed care, and what potential way of monitoring these problems have been identified?

Global questions continued:

3. What if any changes might be made to the scope of covered or "routine" services to be included in a per diem rate?

4. Will either "financial" or "clinical" eligibility criteria for LTC Medicaid change in any way?

    a. If it is anticipated that clinical or financial eligibility might change, what entity will determine the methodology of eligibility for services; and what entity will administer the eligibility determination process? What assessment tool will be used?

5. **New CMS Rules** – How will the new Proposed CMS Medicaid Managed Care Rules impact this process? How will "actuarially sound" rate setting impact budgets?

Thank you for this opportunity, your time, and attention!

We are available to answer questions